Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

RIGHTS & CONSENT TO TREATMENT

- You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- You have the right to be treated in accordance with professional and ethical standards of conduct.
- You have the right to confidentiality. We will not disclose any information outside of the Chrysalis Center without your written consent. Personal Health Information (PHI) will be maintained in a secure, locked environment. Electronic records are maintained with a secure, dual firewall system called InSync. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order. We will not sell your information to anyone for any reason.
- I understand that if Chrysalis shares any information, we will adhere to the "minimum necessary" rule to protect your confidentiality and we will not share Psychotherapy Notes with any third parties.
- You have the right to discontinue services at any time. However, it is expected that you will confer with your clinician(s) rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- I understand that sessions typically run for 38-52 minutes and will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjustedaccordingly.
- I consent to take part in treatment with my clinician(s). I understand that it is in my best interest to actively participate intreatment and follow treatment recommendations.
- I understand and give my consent to the use of Blueprint, a HIPAA-compliant web and mobile platform that helps me and my provider measure progress throughout treatment and make adjustments to treatment as needed.
- I understand and consent to the use of Recovery Record Service, a HIPAA-compliant web and mobile platform for eating disorder education and management to record and evaluate recovery goals and progress.
- I understand that there is no guarantee that any particular outcome will result from treatment.
- I understand and give my consent for the Chrysalis Center clinical staff to consult with each other as needed in order toprovide me with the most effective, ethical treatment possible. The clinicians and dietitians actively collaborate and consult about mutual cases, as well as share clinical notes.
- I understand that my clinician may consult and share clinical information with their supervisor and/or clinical board and/or university in order to provide legal and ethical treatment. They may also do so to meet the requirements set forth for licensure or certification. If I am being seen by an intern, I understand that they are not yet licensed and are practicing under the auspices of their graduate program, not Chrysalis Center.
- I understand that all communications with Chrysalis staff, including digital interactions, will be part of my clinical record. Any digital communication will be limited to that which does not compromise the clinical relationship or professional and ethical standards. I will discuss appropriate ways to use digital technology with my clinician(s). I understand that any communication via social media is prohibited. If I choose to communicate via digital media (cell phones, text, email, etc.), I understand that the confidentiality of these interactions cannot be guaranteed, although Chrysalis-based digital communications will utilize appropriate security measures.

I have read and understood this document and will address any concerns or questions with my therapist and/or the administrative manager. Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws.Current copies of this agreement can be requested anytime and are available on our website.

Client/Representative Signature_____ **Date** _____

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Clinician Signature_____ **Date** _____

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ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES & CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you,_____, and Chrysalis Center. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his or her name(s) here _____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you, with others who need it to arrange payment for your treatment, or with others for other business or government functions. By signing this form, you are agreeing to let us use your information and send it to others under the circumstances described in ourNotice of Privacy Practices. Please read this Notice before you sign this form; it explains in more detail your rights and how we can use and share your information.

In the future we may change how we use and share your information; therefore, our Notice of Privacy Practices may change. If this occurs, you can get an updated copy from our website, www.chrysaliscenter-nc.com, or by calling us at 910-790-9500. If you have any questions regarding the Notice or your privacy rights, you can also contact Kaitlyn Patterson, LPA at kaitlyn.patterson@chrysaliscenter-nc.com or at the contact information listed above.

Please note that it is your right to protect your information. If you have concerns about the use or share of your information for treatment, payment, or administrative purposes, please submit a written request to our Assistant Clinical Director at Chrysalis Center about these concerns. (Although we will try to respect your wishes, we are not required to agree tothese limitations.) Furthermore, you have a right to revoke this consent after you have signed it (by submitting a letter). Any information used or shared prior to annulment of this consent cannot be changed.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to detail what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations; more information about these limitations is detailed in the Notice of Privacy Practices. If you object to any of these practices, you may discuss them with our staff and/or provide written documentation of your concerns. After you have signed this consent, you have the right to revoke it (by writing a letter to our Assistant Clinical Director telling us you no longer consent) and we will comply with your wishes as thoroughly as we are able to do so under the law.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Chrysalis Center's Notice of Privacy Practices. My signature indicates that I have reviewed this notice, understood its content, and agree to its stipulations.

Signature:_____ Date: _____

Printed Name:_____ Date of Birth: _____

Relationship to Client (if guardian or representative):

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (relationship to the client, power of attorney, healthcare surrogate, etc.).

□ I would like to opt out of receiving any fundraising, business or marketing communications from Chrysalis.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

□ ***Client Refuses to Acknowledge Receipt****:*

Signature of authorized representative of this office or practice: _____

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OFFICE PROCEDURES AND FINANCIAL AGREEMENT

Please read, initial, complete, and sign below. You may request a copy for your records.

Chrysalis is a business office where a number of mental health professionals, registered dietitians, and a psychiatric provider practice. Your contract for services is with our office and applies to any and all providers you may see here.

APPOINTMENTS: All office visits are by appointment and scheduled through our administrative staff. Please arrive on time, as you cut down on your appointment time when you arrive late. Appointment lengths vary depending on the type of provider seen. If you arrive more than 15 minutes late for a 50 minute appointment or 7 minutes late for a 30 minute appointment, you will be asked to reschedule your appointment, which will result in a late cancellation charge.

RECORDING DEVICES: The use of recording devices by clients, clinicians, and other persons present during a session, group or other clinical interaction, whether face-to-face or taking place by live textual, audio, or video link is strictly prohibited. Administrative calls may be monitored for quality assurance.

BLUEPRINT: Blueprint respects the privacy of all users and will never sell any personally identifiable data. You own your data at all times and can always request your data and account to be deleted by sending an email to support@blueprint-health.com with the subject of "Account Deletion." You can view Blueprint's privacy policy in detail at www.blueprint-health.com/privacy. Measuring your progress through Blueprint may be considered a billable service by your provider towards your insurance plan and as a result may result in additional co-payments, amounts applied to deductibles, and other amounts that may be deemed the responsibility of the patient as required by contract with the insurance plan and state regulations.

PAYMENT: Payment is required at the time services are rendered, whether you are a self-pay client or have insurance coverage. Acceptable methods of payment include cash, check, VISA or Master Card. *The fee for returned checks is $35. If a check is returned, you will be asked to arrange another method of payment.*

All clients are required to place a credit card on file in order to facilitate collection of payment. If estimated payment (copay, deductible, coinsurance, cash rates) is not received by the end of the date of service, the card on file will be charged. In the case that insurance reimburses different amounts than the estimated payment (copay, deductible, coinsurance, cash rates) taken, credits and debits will be applied to the card as necessary. If the card declines, you will have until one business day prior to your next appointment to provide current and valid card information or your scheduled session will be canceled and payment in full will be required before you can reschedule. A patient portal via our electronic medical records system will be provided to view and track payments.

Name (as it appears on the card): _____

Card Number: _____

Phone number of credit card holder:_____ Billing Zip code: _____

Expiration Date:_____ CVV/CVC: _____

Late cancellations/No shows: For a missed or late cancelled appointment, you will be charged up to $90 for the appointment.Please note: both clinical and nutritional appointments must be cancelled no less than one business day before the scheduled appointment. Please be advised that reminders are a courtesy, and you will be billed for late cancellations and no-shows regardless of whether or not you received the reminder message. Repeated late cancellations and/or no-shows may result in dismissal from treatment, at our discretion.

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INSURANCE: As a courtesy to you, we will bill rendered services to your insurance carrier. We do not accept Medicaid. Insurance co-payments, coinsurances, and deductible payments are due at the time of service. However, verification of eligibility and/or benefit information is not a guarantee of payment by your insurer. Your benefits will be determined once a claim is processed by your insurer, which will be based upon your eligibility and the terms of your certificate of coverage applicable on the date services were rendered. In the event of non-payment from your carrier, you are responsible for payment to Chrysalis for services rendered and you will be responsible for handling any disputes with your insurance carrier. It is your responsibility to be aware of your insurance benefits and needs for pre-authorization. Any services not covered by your insurance are the client's responsibility to pay at our self-pay rates.

Unless otherwise notified, the insurance policy holder will be financially responsible for any balance on the client's account. Please
make one of our administrative staff aware if the billing address is different than the home address on file.

Please note: Treatment information including diagnosis, type of treatment, costs of service, dates of service, and providers may be shared with your insurance carrier for reimbursement purposes. Please be aware that any information communicated to your carrier may affect your benefits. If you decide to file through insurance, we reserve the right to share this information with your carrier upon their request.

OUTSTANDING BALANCE: You are responsible for paying any outstanding balances due on your account. Once we receive an Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount. If anaccount accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Chrysalis does not receive payment in full for services rendered, your treatment may be discontinued.
If you are unable to pay your balance in full, a signed *payment plan agreement* will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuation of services. If you previously discontinued your care or were discharged from treatment and you desire to resume receiving services at Chrysalis, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with our administrative staff. Any balance not paid in 90 days will be subject to collections.

Late Fees: A late fee of $25 will be charged to delinquent accounts that are not paid within 90 days of the issue date of the first bill and may also be referred to a third-party collection agency. You will continue to be responsible for all associated collections and fees.

ADDITIONAL SERVICES: In some circumstances, depending on the time involved and nature of task, you may be charged for additional services, such as extended sessions, scoring psychological testing, preparing a psychological report, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment. Phone calls that are extended and/or that constitute therapy may require an additional fee. These additional services will be charged up to $100/hour.

Testing Fees: Charges for psychological testing apply to all tests taken and scored. Sometimes, insurance companies do notreimburse for testing. In this event, you will be responsible for uncovered testing costs at our self-pay rate.

Conjoint Sessions (with more than one therapist): Conjoint sessions will be billed according to your benefits, which may result in a self-pay rate.

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Paperwork: No provider at Chrysalis will fill out any forms (FMLA, short- or long-term disability, etc.) for clients who are not already established at Chrysalis (5+ sessions with one provider), and at the clinician's discretion. Providers have the right to decline paperwork requests that they are unable/unwilling to complete. Processing time may vary. Paperwork fees are based on the complexity of the paperwork. Providers may also require an appointment be scheduled to fully complete the paperwork. The following fee schedule applies:

- Simple letter or disability initial form requiring less than a paragraph (ex. letter for exemptions for work/jury duty, verification of treatment) = $20.00
- Moderately complex letter or disability form (ex. request for accommodations, ESA) = $40
- High complexity letter or disability form (e. FMLA/disability/LOA, anything more detailed than 1-2 pages) = $60
- Client requested communication with individuals not directly involved in client's treatment (such as teachers, lawyers, etc.): These fees are usually not reimbursable by your insurance and will not be submitted for payment. Self-pay is required at the rate of $30 per 15 minutes. If your provider would prefer that you be present, you will be billed for an office visit.
- Court-related costs: Our providers generally DO NOT testify in court, if your provider is subpoenaed to testify in court, a fee of $300 per hour (including preparation time and travel time) will be charged.
- Psychotherapy with your medication management provider: Cost and treatment plan may vary depending on the nature and length of session.
- Self- Pay rate 16-37 minutes= $50
- 38-52 minutes= $75

Changes to the Policy: Chrysalis Center reserves the right to change this agreement as necessary and in accordance with allapplicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

_____I have read, understand, and agree to the above policies.
_____I authorize Chrysalis to release any information acquired in the course of my therapy to my insurance company as needed.
_____I understand my insurance coverage is a relationship between me and my insurance company and I agree to acceptfinancial responsibility for payment of charges incurred.
_____I have been offered a copy of these policies to take with me if I desire.
_____I understand that the credit card on file will be charged for services rendered if I do not make alternative arrangements attime of service
_____I have discussed these policies and addressed concerns and questions with the administrative staff if needed.
Initial and date by administrative staff if questions were addressed:_____

_____ _____
Signature of Client Date

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

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Communications Policy

Contacting Providers

When you need to contact your provider for non-emergent situations, these are the most effective ways to get in touch in a reasonable amount of time:

- By phone (910-790-9500). Our clinicians do not have direct voicemails, but you can leave a message or leave a confidential voicemail with our administrative staff.
- If you wish to communicate by email, please discuss further with your clinician. Please review the Rights and Consents about the potential confidentiality risks of doing so

Please refrain from making contact with any member of your treatment team using social media messaging systems. Any communication through social media is strictly prohibited as it can create significant security risks for clients.

Please refrain from contacting you provider using SMS (normal phone text messages).

Your provider may utilize HIPAA-compliant mobile and web platforms (e.g., Blueprint, Recovery Record) to support therapeutic goals and measure treatment progress.

- These services are HIPAA-compliant to keep patient information secure even when shared with treatment teams.
- These platforms do not give medical, legal, or psychological advice, diagnoses, or treatment. These services may provide helpful Health-Related Information, but are not intended to substitute for professional advice, diagnoses, treatment, or your judgment.
- Under no circumstances should these services be used to report emergencies to your providers. Chrysalis providers will not be monitoring these services at all times.

Confidentiality is vital to therapy. Please speak with your provider about any concerns you have regarding preferred communication methods.

Response Time

Our office is open Monday-Thursday 8:30am-5pm and Fridays 8:30am-4pm. Our administrative and clinical staff may not be able to respond to your messages and calls immediately. For voicemails and other messages, you can expect a response within *48 hours* (weekends are excepted from this timeframe). It is likely you will receive a reply more quickly than that, but please be aware that this will not always be possible.

Be aware that there may be times when your clinician may be unable to receive or respond to messages, such as when out of cellular range or out of town.

Emergency Contact

If you are ever experiencing an emergency, including a mental health crisis, please call the local police by calling 911 or go to your nearest emergency department. Possible locations include:

New Hanover Regional Medical Center
910-343-7000
2131 17th St.
Wilmington, NC 28401

Cape Fear Hospital
910-452-8100
5301 Wrightsville Ave.
Wilmington, NC 28403

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Following your call to 911 or your visit to your nearest emergency department, if you need to reach your provider, the best methods of communication are:

- By the main office line: 910-790-9500
- If you cannot reach someone by phone, please leave a voicemail

Disclosure Regarding Third-Party Access to Communications

Please know that if we use electronic communications methods, such as email, texting, online video, and possibly others, there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others. While we take precautions whenever possible to ensure the confidentiality of communication through these methods, we cannot always guarantee your confidentiality. Use of these modes of communication implies your understanding and consent to this limitation of confidentiality. Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

I authorize that the following communications from the practice be delivered to me by the provided electronic means. I understand that some forms of electronic communications may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and will not hold the practice responsible should such incident occur. Chrysalis will not use my information for fundraising, business, or marketing communications.

Communications (check all that apply):

☐**Email**

☐**SMS text messaging (for administrative purposes only)**

I understand and agree that the requested communication method(s) is not secure, making my PHI at risk for receipt by unauthorized individuals. I accept the risk and will not retaliate against the practice in any way should this occur.

Client/Representative Signature _____ Date_____

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**Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.*

Please Note: Your insurance carrier requires us to gather this information in order to use your benefits, andthe following information is not available on your insurance card. You must complete all fields on both pages of this form. If you do not provide us with accurate information, your claims may not be processed appropriately, and you will be charged the full rate for services already rendered.

_____Please initial if you do not want to use your insurance benefits; you will be chargedthe self-pay rate for services.

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): _____

Address: _____

Telephone: _____ Date of Birth: _____

Social Security Number: _____ Relationship to Policy Holder:_____

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

Policy Holder's Telephone: _____ Policy's Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number of Member ID Number: _____

Group Number: _____

Secondary Insurance Information (If applicable):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

Policy Holder's Telephone: _____ Policy's Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number of Member ID Number: _____

Group Number: _____

I have read and completed the information above and verify that it is correct. I understand that it is myresponsibility to update Chrysalis with any change in insurance information.

_____ _____

Name of Client (printed) Date

_____

Signature

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Medication Management Policies

Refills: Medication quantities are prescribed in accordance with your treatment plan and the mutually agreed upon frequency of follow-up appointments. A refill fee of $20.00 will be charged upon the request for medication outside of a scheduled appointment time. If you are prescribed a controlled substance, these medications will not be refilled early. If your medication is lost, stolen, forgotten on a trip, etc., you must wait until your next appointment for a refill. The psychiatric provider is legally required to see you at least every 3 months to prescribe controlled substances. It is the patient's responsibility to appropriately schedule follow-up appointments. Failure to do so may also result in termination of medication management services.

Phone calls to Prescriber: When contacting the office regarding medication management, if you are unable to resolve an issue through the medical assistant and require a phone call from the prescriber, please note you may be charged for that call.

Required Appointments: Appointments with the medication management provider are required to discuss medication change requests or to give/receive updates regarding the treatment plan or care of yourself or your child.

Lack of follow-up: Lack of follow-up for 6 months will automatically result in your case being made inactive with our practice. Should you desire to resume treatment, you will be required to schedule a new patient appointment and fill out intake paperwork.

Termination of Medication Management Services: Termination of treatment will occur for non-compliance with our agreed upon treatment plan, including repeatedly canceling or missing appointments, not taking medication as prescribed, fraudulent use of controlled substances, or need for a higher level of care. We reserve the right to terminate treatment for any inappropriate or illegal behavior towards your provider or staff. We also reserve the right to refer you for clinical services outside of Chrysalis if the necessary treatment cannot be ethically or effectively delivered by our staff.

Client/Representative Signature _____ Date_____

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CONFIDENTIAL CLIENT INFORMATION

Welcome to Chrysalis Center. Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal laws, any information you provide is strictly confidential. ***If you do not complete these forms in their entirety prior to your first appointment, you will not be able to see any provider at Chrysalis Center.***

Demographic Information:

Name: _____ SSN: _____ Preferred Name: _____
Pronouns: _____ Gender: _____ Preferred Language: _____
Mailing Address: _____
_____
City: _____ State: _____ Zip Code: _____
Email Address: _____
Primary Phone: _____ Is it okay to leave a message? Yes No
Date of Birth: _____ Age: _____ Race: _____
Ethnic Group: _____ Religious Preference: _____
Relationship status: ____Single ____Cohabitating ____Married ____Separated ____Divorced ____Widowed
Emergency Contact: _____ Telephone: _____
Relationship to you: _____
Parent/Guardian Name (if relevant): _____
Address: _____ Telephone: _____

Referral/Clinical Information:

How did you find out about our services? _____
What issue(s) bring(s) you here? _____
_____

What has been stressing you as of late? (Family, job, recent loss of loved one, financial issues, etc)

_____
_____
_____

Employment/Education Information:

Are you currently employed? Yes No
If yes, where are you employed? _____
What is your job title? _____
Highest Level of Education Completed: _____
Are you currently a student? Yes No
If yes, where? _____ Year_____ Major_____

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Social History:

Where do you live? _____

Who lives with you? _____

_____

_____

Are you married? Yes No If so, for how long? _____

Have you been married in the past? Yes No Number of times? _____

Do you have children? Yes No

If so, how many? _____ What are their ages? _____

What do you do in your free time to relax?

_____

_____

Do you have any religious beliefs? Yes No

How important are your religious/spiritual beliefs in your life?

_____

Have you had any legal issues (arrests, charges, time in jail)? Yes No

If so, please describe. _____

Family/Significant Others:

Please list any blood relatives who have been diagnosed with the following conditions.

	Name	Relationship to you	Age
Alcoholism			
Anxiety disorder			
Bipolar disorder			
Cancer			
Depression			
Diabetes			
Drug abuse			
Heart disease/high blood pressure/arrhythmias			
Osteoporosis			
Seizures			
Schizophrenia			
Strokes			
Suicides			
Thyroid disease			

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Health Information:

CONSTITUTIONAL:
Yes No
☐ ☐Weight Loss
☐ ☐Fatigue
☐ ☐Fever

EYES:
Yes No
☐ ☐Glasses/Contacts
☐ ☐Eye Pain
☐ ☐Double Vision
☐ ☐Cataracts

EAR,NOSE,THROAT:
Yes No
☐ ☐Difficulty Hearing
☐ ☐Ringing in Ears
☐ ☐Vertigo
☐ ☐Sinus Trouble
☐ ☐Nasal Stuffiness
☐ ☐Frequent Sore Throat

CARDIOVASCULAR:
Yes No
☐ ☐Murmur
☐ ☐Chest Pain
☐ ☐Palpitations
☐ ☐Dizziness
☐ ☐Fainting Spells
☐ ☐Shortness of Breath
☐ ☐Difficulty lying Flat
☐ ☐Swelling Ankles

ENDOCRINE:
Yes No
☐ ☐Loss of Hair
☐ ☐Heat/Cold Intolerance

RESPIRATORY:
Yes No
☐ ☐Cough Easy
☐ ☐Coughing Blood
☐ ☐Wheezing
☐ ☐Chills

GASTROINTESTINAL:
Yes No
☐ ☐Heartburn/Reflux
☐ ☐Nausea/Vomiting
☐ ☐Constipation
☐ ☐Change in BMs
☐ ☐Diarrhea
☐ ☐Jaundice
☐ ☐Abdominal Pain
☐ ☐Black or Bloody BM

GENITOURINARY:
Yes No
☐ ☐Burning/Frequency
☐ ☐Nighttime
☐ ☐Blood in Urine
☐ ☐Erectile Dysfunction
☐ ☐Abnormal Discharge
☐ ☐Bladder Leakage

ALLERGIC/IMMUNOLOGIC:
Yes No
☐ ☐Hives/Eczema
☐ ☐Hay Fever

PSYCHIATRIC:
Yes No
☐ ☐Anxiety/Depression
☐ ☐Mood Swings
☐ ☐Difficult Sleeping

HEMATOLOGY/LYMPH:
Yes No
☐ ☐Easy Bruising
☐ ☐Gums Bleed Easily
☐ ☐Enlarged Glands

MUSCULOSKELETAL:
Yes No
☐ ☐Joint Pain/Swelling
☐ ☐Stiffness
☐ ☐Muscle Pain
☐ ☐Back Pain

SKIN:
Yes No
☐ ☐Rash/Sores
☐ ☐Lesions
☐ ☐Itching/Burning

NEUROLOGICAL:
Yes No
☐ ☐Loss of Strength
☐ ☐Numbness
☐ ☐Headaches
☐ ☐Tremors
☐ ☐Memory Loss

Please list any chronic illnesses, injuries, physical conditions, or disabilities:_____

_____

Please list any previous surgeries: _____

_____

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Allergies (including food allergies) or Adverse Reactions to Treatment:_____

_____

Primary Care Physician Name: _____

Date of Last Physical:_____ Telephone: _____

Current Medications, Supplements, Vitamins	Daily Dose	For what Condition	Name of Prescriber

If applicable:

Date of last menstrual period? _____

Do you use any birth control? Yes No If so, please list? _____

Have you been pregnant before? Yes No If so, how many times? _____

Miscarriages? Yes No Elective abortions? Yes No

Any depression or unreal thoughts around pregnancies? Yes No

Safety:

Have you ever been the victim of a violent crime? Yes No

Have you ever been a victim of physical abuse? Emotional abuse? Sexual abuse or rape? Yes No

_____

Do you currently have any thoughts of hurting yourself? Yes No

If so please explain._____

Have you tried to hurt yourself in the past? Yes No

If so please explain._____

Do you currently have thoughts of hurting anyone else? Yes No

If so please explain._____

Have you tried to hurt anyone in the past? Yes No

If so please explain._____

Do you own any guns or knives? Yes No

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Substance Use History:

	Last time used?	How often? # of times per week, month, or year	How much do you use in a sitting if/when you do use?
Tobacco			
Alcohol			
Marijuana or K2/"spices"			
Cocaine			
Opiates (heroin, morphine, Percocet, oxycodone, Tylenol #3, dilaudid/hydromorphone)			
Tranquilizers/sedatives (Xanax, Ativan, Klonopin, Valium			
PCP or LSD			
Mushrooms			
Others			

Past Psychiatric Care:

Have you ever been diagnosed with a mental health condition by a medical provider (e.g., depression, bipolar, schizophrenia, ADHD)? Yes No

If so, please list. _____

Have you ever been seen by a psychiatrist or therapist/counselor? Yes No

If so, please list and describe.

Date(s) seen?	By whom?	For what problem?	What treatment (meds, ECT, therapy)?

Have you ever been hospitalized for psychiatric care? Yes No

If so, please list and describe.

Date(s) seen?	By whom?	For what problem?	What treatment (meds, ECT, therapy)?

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Have you ever been treated with any of the following medications?

Med	Good/bad effects	Med	Good/bad effects	Med	Good/bad effects
Abilify		Halcion		Ritalin	
Ambien		Haldol		Saphris	
Adderall		Hydroxzine		Seroquel	
Anafranil		Klonopin		Soma	
Antabuse		Invega		Strattera	
Atarax		Lamictal		Suboxone/ subutex	
Ativan		Latuda		Tegretol	
Buspar		Lexapro		Thorazine	
Campral		Librium		Topomax	
Celexa		Lithium		Trazodone	
Clonidine		Lunesta		Trileptal	
Clozaril		Luvox		Valium	
Cogentin		Methadone		Vibryd	
Concerta		Paxil		Vistraril	
Cymbalta		Pristiq		Vivitrol	
Depakote		Prolixin		Vyvanse	
Effexor		Propranolol		Wellbutrin	
Elavil		Remeron		Xanax	
Fanapt		Restoril		Zoloft	
Fluoxetine		Risperdal		Zyprexa	
Geodon					

Any other psychiatric medications you have taken?

_____

_____

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3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

Exchange of Information

Client Name: _____ Date of Birth: _____

Primary Care Physician Information:

PCP Name: _____ PCP Phone Number: _____

PCP's Address: _____

City: _____ State: _____ Zip Code: _____

PCP's Fax Number: _____

I hereby freely, voluntarily and without coercion, authorize the behavioral health clinician/ facility listed below to release the information contained on this form to the clinician/facility listed above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last 1 year from the date signed. I understand that I may revoke my consent at any time.

Signature: _____ Date: _____
(of client or representative)

To Be Completed by Provider

The client is being treated for the following behavioral health problem(s):

☐ADHD/Behavior D/O ☐Substance Abuse ☐Psychotic Disorder ☐Bipolar D/O

☐Depressive Disorder ☐Anxiety Disorder ☐Eating Disorder ☐Mood Disorder

☐Adjustment Disorder ☐Other: _____

The client is taking the following prescribed psychotropic medication/s:

_____

_____

_____

Outpatient care:

☐Medication Management ☐Individual Therapy ☐Nutritional Counseling ☐Intensive Outpatient Program

Coordination of care issues/ Other significant information impacting medical or behavioral health:

_____

_____

_____

Signature of Clinician: _____ Date:_____

Date form mailed or faxed to other clinician/facility: _____

(place a completed copy of this form on the patient's medical record)

THIS IS NOT A REQUEST FOR RECORDS